Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	002408	A. BUILDING: _____ B. WING _____	04/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUPONT HOSPITAL LLC	2520 E DUPONT RD FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of one State hospital complaint. Complaint Number: IN00122949: Unsubstantiated; lack of sufficient evidence Date: 4/15/13 Facility Number: 002408 Surveyor: Linda Plummer, R.N. Public Health Nurse Surveyor Dupont Hospital LLC., is in compliance with 410 IAC 15-1.5.5-6, Nursing Services, Hospital Licensure Rules. QA: claughlin 04/23/13	S 000		